INDIVIDUALIZED SERVICE PLAN

If applicable: Medicaid # _____

DMAS Provider ID#_____

Resident's Name:_____ Name of ALF: _____

See reverse side for signatures and additional information.

Description of needs is based upon the UAI, medical reports, and any additional assessments necessary to meet the care needs of the resident.

A. If the resident lives in a building housing 19 or fewer residents, does the resident need to have a staff member awake and on duty at night? ☐ Yes ☐ No

B. Description of Needs and Date Identified	**Services to be Provided**	**Persons Who will Provide Services**	**When and Where Services will be Provided**	**Expected Outcomes/Goals (Include Time Frames)**

Resident's Name: _____

B. Description of Needs and Date Identified	Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes/Goals (Include Time Frames)

SIGNATURES:

_____	_____	_____	_____
Staff Person Who Completed Plan	**Date Plan Completed**	**Resident**	**Date**

_____	_____	_____	_____
Licensed Health Care Professional (480)	**Date**	**Other, if any, Involved in Development of Plan (Specify Title/Relationship)**	**Date**

PLAN REVIEW/MODIFICATIONS

NOTE: Changes in plan should be initialed by staff person making change, resident, and for assisted living care residents, licensed health care professional (630.J).

Staff Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: _____

Dates Implementation Monitored and Initials: _____ _____ _____ _____ _____

SIGNATURES:

_____	_____	_____	_____
Staff Person Who Completed Plan Review	**Date**	**Staff Person Who Completed Plan Review**	**Date**